STATE OF MICHIGAN
IN THE SUPREME COURT

ALBERTA STUDIER, PATRICIA M. SANOCKI, MARY A. NICHOLS, LAVIVA M. CABAY, MARY L. WOODRING, AND MILDRED E. WEDELL,

Plaintiffs-Appellees,

v.

MICHIGAN PUBLIC SCHOOL EMPLOYEES' RETIREMENT BOARD, MICHIGAN PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM, MICHIGAN DEPARTMENT OF MANAGEMENT AND BUDGET, AND TREASURER OF THE STATE OF MICHIGAN,

Defendants-Appellants,

Supreme Court No's. 125765
125766
Court of Appeals No. 243796

Ingham County Circuit Court
No. 00-92435-AZ

***AMICUS CURIAE* BRIEF OF COUNTY OF ST. CLAIR**

GARY A. FLETCHER (P26823)
WILLIAM L. FEALKO (P52156)
Fletcher Clark Tomlinson
Fealko & Monaghan, P.C.
Attorneys for *Amicus Curiae*
County of St. Clair
522 Michigan Street
Port Huron, Michigan 48060-3811
(810) 987-8444

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

The issue pending before the Court involves a governmental entity's ability to modify the health care benefits provided to its retirees. The County of St. Clair, Michigan (the "County") employs approximately six hundred (600) full-time employees and has approximately four hundred (400) retirees. Since January 1, 1977, the County has been providing health insurance and prescription drug coverage to its retirees. In the last decade, the County has experienced an unprecedented escalation in the costs of providing these health benefits to retirees. From 1999 to 2003, the County's health care costs increased by 111.67% to $2,084,009.59. (County Administrator/Controller Troy Feltman Affidavit ¶ 3, see Appendix A-1). The County projected that if no changes were made to restrain the growth in retiree health care costs, the County would be spending $4.5 Million for such costs by 2007. (Singer Affidavit ¶ 10, see Appendix A-5).

Confronted with escalating costs and decreased State revenues, the County concluded it had to take action to slow the rate of growth in retiree health care costs to avoid a future financial crisis. Effective January 1, 2004, the County modified the health insurance provided to retirees from a traditional fee-for-service insurance to a preferred provider organization plan ("PPO") and modified the prescription drug co-payment it required from retirees, hoping to provide retirees with a financial incentive to use less costly generic drugs and less costly means of filling prescriptions. In response, an association of retirees sued the County seeking to invalidate these changes under the same legal theories being advanced in the instant case. The association's suit is currently pending before Hon. Peter J. Maceroni, sitting as Judge for the St. Clair County Circuit Court.

The County seeks leave to file an *Amicus Curiae* Brief to present the practical impact the Court's ruling in the instant case will have on local governmental entities. As is explained herein,

there is a substantial likelihood that any ruling by this Court will conclusively establish whether local governmental entities have the ability to modify retiree health insurance plans. If local governmental entities are Constitutionally or contractually prohibited from adopting cost-saving measures for retiree health care costs in response to escalating costs and changing demographics, local governmental entities will be facing a financial crisis that will undermine their ability to provide core services to their constituents. Just as troubling is that a ruling denying local governmental entities the ability to adopt measures designed to save health care costs would likely create a proverbial "race to the bottom," as local governmental entities would eliminate or reduce the health benefits provided to future retirees to minimal levels to avoid creating financial obligations that cannot be satisfied in the future.

STATEMENT OF JUDGMENT APPEALED FROM, MATERIAL PROCEEDINGS, AND STATEMENT OF RELIEF SOUGHT

This is an action filed by six public school retirees challenging certain increases to drug co-payments and deductibles implemented by the Michigan Public School Employees Retirement Board pursuant to the Michigan Public School Employees Retirement Act, MCL 38.1301 *et seq.* The questions presented in this action involve interpretation and application of the provisions of the Michigan Constitution, specifically Const. 1963, art I, § 10 and art 9, § 24, the contract impairment clause of the United States Constitution, US Const, art I, §10, and MCL 38.1391(1).

On February 3, 2004, the Court of Appeals issued its Opinion and Order which ruled: A) health benefits were not "accrued financial benefits" as that term is used in Const 1963, art 9, § 24; B) the statutory scheme of MCL 38.1391(1) creates a contractual obligation on the State, and C) increased co-payments and deductibles do not constitute an unconstitutional impairment of any contractual obligation to provide health insurance under MCL 38.1391(1). Both Plaintiffs and Defendants filed Applications for Leave to Appeal relating to different aspects of the Court of Appeals' ruling. By Orders dated September 16, 2004, this Court granted Plaintiffs and Defendants leave to appeal.

The County of St. Clair (the "County") files this Brief as *amicus curiae* in support of Defendants Briefs on Appeal. The County joins Defendants in asking the Court to affirm the Court of Appeals' ruling that health care benefits are not "accrued financial benefits" as such phrase is used in Const 1963, art 9, § 24, reverse the Court of Appeals ruling that MCL 38.1391(1) creates contractual obligations, declare that no statute or ordinance will be found to create a contractual obligation absent an express statement that a "contractual obligation" is intended; and affirm the

Court of Appeals' ruling that increased co-payments and deductibles do not constitute a significant impairment of any obligation to provide health insurance.

STATEMENT OF JURISDICTION

This Court has jurisdiction of this case pursuant to MCR 7.301(A)(2) and 7.302.

QUESTIONS PRESENTED FOR REVIEW

I. Did the Court of Appeals correctly conclude health care benefits are not "accrued financial benefits" under Const 1963, art 9, §24?

Court of Appeals' Answer: "Yes"

Plaintiffs' Answer: "No"

Defendants' Answer: "Yes"

Amicus Curiae St. Clair County's Answer: "Yes"

II. Whether the health benefits described in MCL 38.1391(1) are a contractual obligation that cannot be diminished or impaired by the State?

Court of Appeals' Answer: "Yes"

Plaintiffs' Answer: "Yes"

Defendants' Answer: "No"

Amicus Curiae St. Clair County's Answer: "No"

III. Whether increasing retiree co-payments and deductibles substantially impairs a contractual obligation to provide health care benefits in violation of Const 1963, art I, § 10 and US Const, art I, § 10?

Court of Appeal's Answer: "No"

Plaintiffs' Answer: "Yes"

Defendants' Answer: "No"

Amicus Curiae St. Clair County's Answer: "No"

STATEMENT OF FACTS

Amicus Curiae County of St. Clair adopts the Statement of Facts set forth by Defendants-Appellants Michigan Public School Employees' Retirement Board, Michigan Public School Employees' Retirement System, Michigan Department of Management and Budget, and Treasurer of the State of Michigan (collectively the "State") in their respective Briefs. The Statement of Facts by the State is supplemented by two accompanying affidavits explaining the County of St. Clair's actual experience with retiree health care matters, excerpts from the County's Retirement Ordinance, and County Resolution 76-63.

ARGUMENT

I. THE COURT OF APPEALS CORRECTLY CONCLUDED THAT HEALTH BENEFITS DO NOT CONSTITUTE "ACCRUED FINANCIAL BENEFITS" AS THAT PHRASE IS USED IN CONST 1963, ART 9, § 24.

A. Standard of Review

The standard of review for constitutional issues is *de novo*. McDougall v Schanz, 461 Mich 15, 23; 597 NW2d 148 (1999).

B. Michigan Constitutional and Statutory Provisions

Prior to the adoption of the 1963 Michigan Constitution, Michigan courts had ruled that financial benefits set forth in a public retirement program were "not contractual obligations but gratuitous allowances which could be revoked at will by the authority." Advisory Opinion re Constitutionality of 1972 PA 258, 389 Mich 659, 662; 209 NW2d 200 (1973). To negate this ruling, the Michigan Constitutional Convention proposed a provision, which ultimately became Article IX, Section 24 of the 1963 Michigan Constitution. This provision states:

> The **accrued financial benefits** of each pension plan and retirement system of the state and its political subdivisions shall be a contractual obligation thereof which shall not be diminished or impaired thereby. Financial benefits arising on account of service rendered in each fiscal year shall be funded during that year and such funding shall not be used for financing unfunded accrued liabilities. [Emphasis added.]

See also 1 Official Record, Constitutional Convention 1961, 770-771.

Whether Article IX, Section 24 should be read to prevent the diminution of any employee benefit, including, most notably, health care benefits has been the subject of recent litigation. In the instant case, the Michigan Court of Appeals concluded "health benefits are not accrued financial benefits as that term is used in Const 1963, art 9, § 24." Studier v MPSERS, 260 Mich App 460; 769 NW2d 88, 96 (2004). The County believes the Court of Appeals correctly analyzed the

legislative history underlying the adoption of Article 9, Section 24 of the 1963 Michigan Constitution. The County further believes the Court of Appeals correctly concluded the phrase "accrued financial benefits" does not include health benefits, as there are significant policy reasons to differentiate between the treatment provided to benefits relating to retirement income, i.e. financial benefits, and benefits relating to the provision of health care.

In 1974, the United States Congress enacted the Employee Retirement Income Security Act ("ERISA"). While ERISA does not apply to government-sponsored plans, the public policies underlying ERISA's differential treatment of private pension and welfare plans are relevant to this analysis. 29 USC §§ 1002(1). ERISA imposes minimum vesting standards for pensions plans (plans established for providing retirement income); however, ERISA specifically exempts welfare plans (plans established for providing employee benefits such as "medical, surgical or hospital care or benefits") from the vesting requirements. 29 USC § 1051(1). The United States Court of Appeals for the Second Circuit explained:

> Automatic vesting was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in the cost of treatment independent of inflation. These unstable variables prevent accurate prediction of future needs and costs. [Moore v Metropolitan Life Ins Co, 856 F2d 488, 492 (2d Cir 1988).]

Congress was further concerned that imposing vesting requirements on welfare plans would create a significant disincentive for employers to offer health benefit plans in the first place.

> Giving employers this flexibility also encourages them to offer more generous benefits at the outset, since they are free to reduce benefits should economic conditions sour. If employers were locked into the plans they initially offered, "they would err initially on the side of omission." [Intermodal Rail Employees Ass'n v Atchison, Topeka & Santa Fe Railway Co, 520 US 510, 515; 117 SCt 1513; 137 LEd2d 763 (1997) (citations omitted).]

As a result of these concerns, employers and plan sponsors under ERISA may "adopt, modify, or terminate welfare plans ... for any reason at any time." Curtiss-Wright Corp v Schoonejongen, 514 US 73, 78; 115 SCt 1223; 131 LEd2d 94 (1995). The same significant policy concerns underlying Congress' differential treatment of welfare benefit plans under ERISA support the Court of Appeals ruling in the instant case.

The County's experience in providing retirees with health benefits demonstrates the need for a flexible approach. The County began providing health insurance and prescription drug coverage for retirees in 1977. Since that time, the health insurance market has undergone a complete transformation. One of the most notable changes has been the development of new insurance products, such as Preferred Provider Organizations ("PPOs") and Health Maintenance Organizations ("HMOs"). (Singer Aff ¶ 9). In a PPO, the insurance company contracts with medical providers, who agree to charge for services based upon a negotiated fee schedule, which represents a discounted rate from the normal fee for service charges. (Singer Aff ¶ 9). In a HMO, the insurance company seeks to ensure that only necessary health services are utilized by restricting access to health care through a so-called gatekeeper. (Singer Aff ¶ 9). Both PPOs and HMOs have been used by employers to restrain the growth of health care costs.

Not only has there been a transformation in the health insurance market, there have been significant changes in the prescription drug market. Employers have been able to control the escalating costs of prescription drugs by encouraging the use of generic drugs. (Singer Aff ¶ 7). In 1984, 19% of the prescription drugs sold were generic drugs. (Singer Aff ¶ 7). By 1996, this figure had increased to 46%. (Singer Aff ¶ 7). Encouraging the use of generic drugs has allowed employers to recognize significant cost savings, inasmuch as the average generic drug cost is

approximately $21.00 and the average Name Brand drug cost is $84.00. (Singer Aff ¶ 7). Employers have more recently been able to realize cost savings by encouraging the use of mail-order prescription drug fills, which allow members to obtain a three-month supply of certain so-called maintenance drugs through the mail for the payment of a single co-payment. (Singer Aff ¶ 8). Because mail-order prescription programs have much lower costs, employers are able to achieve significantly lower prescription costs when such are used. To encourage employees and retirees to use lower costs for prescription drugs, employers and insurers will typically require a higher co-payment for persons not using generic drugs or mail order services. (Singer Aff ¶¶ 12-13).

Construing the phrase "accrued financial benefits" in Const 1963, art. 9, § 24 to include health benefits would effectively lock governmental entities into a plan with no means of modifying benefits. Such a ruling would deny governmental agencies the ability to adjust to changing circumstances, would ignore the reality of the health care market, and would provide a significant disincentive to all governmental agencies to provide health insurance in the future. In the County's case, the County's health insurance would be trapped in 1977 and the County would have no ability to provide retirees with a financial incentive to use lower-cost providers or prescription drugs.

II. THE COURT OF APPEALS INCORRECTLY FOUND MCL 38.1391(1) CREATED CONTRACTUAL OBLIGATION ON THE STATE TO PROVIDE HEALTH BENEFITS.

A. Standard of Review

The standard of review for constitutional issues is *de novo*. McDougall v Schanz, 461 Mich 15, 23; 597 NW2d 148 (1999).

B. MCL 38.1391 should not be construed as creating contractual obligations.

Under Michigan law, a contractual obligation based upon legislation is found "only if the legislature has unambiguously expressed an intention to create the obligation." In re Certified Question, 447 Mich 765, 777; 527 NW2d 468 (1994), cert den'd 514 US 1127 (1995). This presumption ensures one legislature does not unintentionally limit the sovereign power of a future legislature. The United States Supreme Court explained:

> The presumption is that such a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise. He who asserts the creation of a contract with the state in such a case has the burden of overcoming the presumption. [Dodge v Board of Educ, 302 US 74, 79; 58 SCt 98; 82 Ld2d 57 (1937).]

Perhaps, there is no better example of an unambiguous expression of a contractual obligation than the language used in Article 9, Section 24 of the 1963 Michigan Constitution, which states "accrued financial benefits ... **shall be a contractual obligation** ... which shall not be diminished." (Emphasis added). Not only does Michigan 1963, art. 9, § 24 evince an unambiguous expression of a contractual obligation, but the language also suggests, by negative implication, that benefits other than "accrued financial benefits" should not be considered contractual obligations. Furthermore, finding MCL 38.1391 does not create a contractual obligation ensures the State has the flexibility to modify health care benefits and to implement necessary cost saving measures.

Many local governmental entities, including the County, use language analogous to MCL 38.1391 in their retirement ordinances and plans. As a result, this Court's ruling will not just be deciding the impact of MCL 38.1391, but will also establish whether local governmental entities throughout the State have a contractual obligation to provide health care benefits. For example, the St. Clair County Retirement System Ordinance states:

> The medical insurance shall provide the levels of coverage stated in this section or their equivalents.
> (a) Blue Cross Blue Shield MVF.1.
> (b) A prescription drug rider with two dollar co-pay.... [County Retirement Ordinance excerpts attached as Appendix A-28.]

Using the Court of Appeals' reading of MCL 38.1931(1), the County retirees have asserted the County has created a contractual obligation to provide prescription drug coverage with a two-dollar co-payment for time immemorial.

The County strongly objects to the suggestion that the above-language constitutes an unambiguous expression of the County's desire to create a contractual obligation. When the County intended to create contractual obligations in the Retirement Ordinance, it did so in unmistakable fashion. Article I Section 1.3(a) of the Retirement Ordinance states:

> The **accrued financial benefits** of each pension plan and retirement system of the state and its political subdivisions **shall be a contractual obligation** thereof which shall not be diminished or impaired thereby. [See Appendix A-28.]

Neither the County's Retirement Ordinance nor MCL 38.1391(1) contain an unmistakable expression of a contractual obligation with respect to the provision of health care benefits.[1]

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[1] In fact, County Resolution 76-63 also included an express statement that the County would "annually evaluate the cost of implementing [the benefits] and forward recommendations to the County Board Commissioners prior to budget review." (See Appendix A-32).

The County asks the Court to conclude MCL 38.1391 does not set forth an unambiguous intention to create a contractual obligation to provide health insurance to retirees. To prevent further litigation, the County would further ask the Court declare that only language expressly acknowledging the intention to create a contractual duty, such as the language used in Const 1963, art. 9, § 24, will be sufficient to establish a contractual obligation from legislation.

III. THE STATE'S MODIFICATION OF HEALTH CARE BENEFITS DOES NOT VIOLATE ART I, §10 OF THE MICHIGAN CONSTITUTION.

A. Standard of Review

The standard of review for constitutional issues is *de novo*. McDougall v Schanz, 461 Mich 15, 23; 597 NW2d 148 (1999).

B. Increased Co-Payments and Deductibles Do Not Impair Contractual Expectancy of Health Insurance

The United States and Michigan Constitutions prohibit the adoption of laws that impair the obligations of contracts. U.S. Const, art I, §10; Const 1963, art I, §10. Courts have applied a three-prong test to determine when statutory provisions violate the impairment of contracts provision: 1) whether the subject law has operated as a substantial impairment of a contractual relationship; 2) whether the legislative disruption of contract expectancies is necessary to the public good, and 3) whether the means chosen by the Legislature to address the public need is reasonable. Allied Structural Steel Co v Spannaus, 438 US 234, 98 SCt 2716, 57 LEd2d 727 (1978).

In the instant case, the Court of Appeals found the only contractual expectancy created by MCL 38.1391(1) was that some form of health insurance be provided to retirees. While the County believes the Court of Appeals' finding of a contractual obligation was erroneous, it is nonetheless significant that the Court of Appeals did not find a contractual expectancy to receive health insurance necessarily equated to a contractual expectancy to receive a specific benefit or service in perpetuity. To rule otherwise would require the State to continue to pay for outdated or inefficient services by virtue of the fact such service was once provided as a benefit.

Just as medical science evolves, the health care market evolves and employers need to have the ability to adapt. The County does not believe the Court can conclude adjustments to co-payments

and deductibles are a substantial impairment to a contractual expectancy of health insurance. Moreover, any impairment of such contractual expectancy is reasonable and necessary for the public good, as the escalating cost of health care is threatening the ability of local governmental entities to provide core services. Michigan and Federal courts have long held that such economic interests justify legislation although such impairs contractual expectancies. Van Slooten v Larsen, 86 Mich App 437, 449; 272 NW2d 675 (1978), aff'd 410 Mich 21 (1980).

RELIEF REQUESTED

Amicus Curiae County of St. Clair respectfully requests the Court:

1) Affirm the Court of Appeals' ruling that health care benefits are not "accrued financial benefits" as such phrase is used in Const 1963, art 9, § 24, thereby ensuring governmental entities have the flexibility to adapt health insurance plans to technological and market changes;

2) Reverse the Court of Appeals ruling that MCL 38.1391(1) creates contractual obligations and declare that no statute or ordinance will be found to create a contractual obligation absent an express statement that a "contractual obligation" is intended by the provision; and

3) Affirm the Court of Appeals' ruling that increased co-payments and deductibles do not constitute a significant impairment of any obligation to provide health insurance.

FLETCHER CLARK TOMLINSON
FEALKO & MONAGHAN, P.C.
Attorneys for Defendant St. Clair County

By: _____
GARY A. FLETCHER
WILLIAM L. FEALKO
522 Michigan Street
Port Huron, Michigan 48060-3811

DATED: November 11, 2004

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF ST. CLAIR

ST. CLAIR COUNTY RETIREES ASSOCIATION (SCCRA), a Voluntary Non-Profit Association,
Plaintiffs,

vs.

File No. K 04-672 CK

COUNTY OF ST. CLAIR, a Michigan Municipal Corporation,
Defendants.

JOHN B. McNAMEE (P27939)
ROBERT W. CARSON (P23259)
McIntosh, McColl, Carson,
McNamee, Strickler & Downey
Attorneys for Plaintiffs
3024 Commerce Drive
Fort Gratiot, Michigan 48059
(810) 385-1500

GARY A. FLETCHER (P26823)
WILLIAM L. FEALKO (P52156)
Fletcher Clark Tomlinson
Fealko & Monaghan, P.C.
Attorneys for Defendants
522 Michigan Street
Port Huron, Michigan 48060-3811
(810) 987-8444

AFFIDAVIT OF TROY FELTMAN

STATE OF MICHIGAN

-ss-

COUNTY OF ST. CLAIR

Troy Feltman, being first duly sworn deposes and says:

1. I have personal knowledge of the facts set forth herein and if called upon to testify would testify consistent with the following statements.

2. I am the Administrator/Controller for the County of St. Clair and have held such position since February 1999.

3. Since I became employed with the County, I have been concerned by the rate at which County health care costs have risen. In 1999, the County paid $984,571.42 for health care benefits (excluding dental) for its general retirees. By 2003, this figure had increased to $2,084,009.59, an increase of 111.67% in four years. A copy of the County's actual health care costs for years 1999 through 2003 is attached as Exhibit A.

4. A significant portion of the County's increased health care costs has been attributable to the rising costs of prescription drugs. From 1999 to 2003, the County's prescription drug costs rose by 133.67%.

5. In 2003, the County hired a consultant, Public Employee Benefits LLC ("PEB"), to review the County's costs for various employee benefits including health care plans, to project the costs of such benefits into the future and to make recommendations on ways to control the growth of those costs.

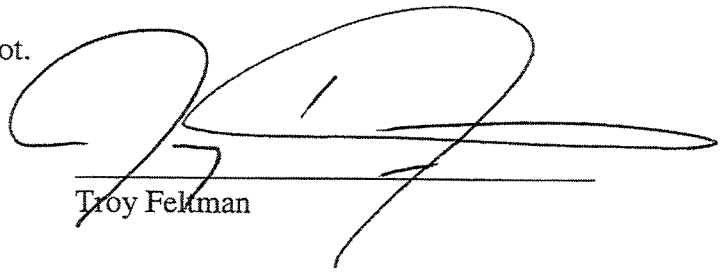
6. PEBS completed their review and submitted a report in August 2003. PEBS projected that if changes were not made to the County's health care, the County's health care costs would exceed $20 Million annually by 2013.

7. If measures were not taken to control the County's escalating health care costs, the ability of the County to provide core services to residents in the future would be undermined. This is especially true given the current uncertainty surrounding funding from the State of Michigan. The State of Michigan is the second-largest funding source for the County. In Fiscal Year 2004 budget, State revenues to the County decreased by 11.6% and additional decreases are expected in the foreseeable future with the likelihood the State will completely eliminate State shared revenue.

8. PEBS recommended that the County change their existing health insurance coverage from Blue Cross/Blue Shield Traditional fee-for-Service insurance to Blue Cross / Blue Shield's Community Blues PPO Option 2 ("Community Blues 2"). PEBS believed the County could provide expanded health insurance coverage for employees and retirees at a slightly higher cost to the County. PEBS also recommended the County modify its existing prescription drug coverage for employees and retirees to promote the use of generic drugs and to provide a mail order option for maintenance drugs. PEBS recommended the County consider adopting a two-tier co-payment structure, whereby employees and retirees would pay a $10 co-payment for generic prescriptions and a $20 co-payment for brand-name prescriptions. This modified co-payment was intended to give employees and retirees with a financial incentive to use the lower-priced generic drugs.

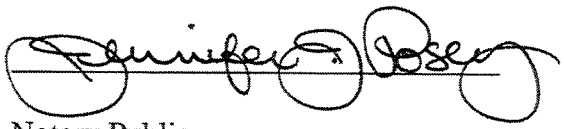
9. When reviewing PEBS' recommendations, the County Board of Commissioners asked County administration to develop a so-called "hardship provision" that would decrease the economic impact the increased co-payments would have on retirees with modest incomes. It was recommended the County adopt a hardship provision, whereby retirees with more than 20 years of service and annual retirement income below $20,000.00 would have a flat co-payment of $5.00. Approximately, 22% of the County's retirees at the time would have qualified for the hardship provision.

10. Further Affiant sayeth not.



Troy Feltman

On the 13th day of April, A.D. 2004, before me personally appeared Troy Feltman and made oath that he has read the foregoing Affidavit by him subscribed and knows the contents thereof, and that the same is true of his own knowledge, except as to the matters which are therein stated to be upon his information and belief, and as to those matters, he believes them to be true.



Notary Public
St. Clair County, Michigan
My commission expires: 7-21-06

JENNIFER J. POSEY
NOTARY PUBLIC ST. CLAIR CO., MI
MY COMMISSION EXPIRES Jul 21, 2006

			RETIREE CLAIMS COMPARISON SUMMARY (General Retirees Only)				
Line of Coverage	HOSPITAL	PHYSICIAN	DRUGS	# OF SCRIPTS	DENTAL	MONTHLY TOTAL	OVERALL % INCREASE
1999 (1/2 yr dental)	$339,036.83	$173,350.14	$472,184.45	11,738	$15,021.20	$999,592.62	
2000	$364,476.54	$195,935.20	$540,001.36	12,209	$49,461.86	$1,149,874.96	15%
2001	$486,094.87	$227,123.75	$704,126.52	13,389	$63,955.87	$1,481,301.01	28.80%
2002	$628,369.85	$242,896.19	$820,606.38	15,027	$59,307.49	$1,751,179.91	18.20%
2003	$678,073.10	$302,547.61	$1,103,388.88	18,294	$74,649.32	$2,158,658.91	23.24%

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Attorneys for Plaintiffs
3024 Commerce Drive
Fort Gratiot, Michigan 48059
(810) 385-1500

GARY A. FLETCHER (P26823)
WILLIAM L. FEALKO (P52156)
Fletcher Clark Tomlinson Fealko & Monaghan, P.C.
Attorneys for Defendants
522 Michigan Street
Port Huron, Michigan 48060-3811
(810) 987-8444

AFFIDAVIT OF MITCHELL SINGER

STATE OF MICHIGAN

-ss-

COUNTY OF ST. CLAIR

Mitchell Singer, being first duly sworn deposes and says:

1. I have personal knowledge of the facts set forth herein and if called upon to testify would testify consistent with the following statements.

2. I am a principal with Public Employee Benefits Solutions, L.L.C. ("PEBS"), an Insurance Agency that provides consulting services to public employers regarding Employee Benefits. I have been working in the insurance industry for 18 years. A current copy of my curriculum vitae, and that of the other Principal of the company is attached as Exhibits A-1 and A-2, respectively.

3. In March 2003, we were asked by St. Clair County (the "County") to review the County's costs for health insurance, life insurance and other benefits; to project the County's future costs based upon cost trends being experienced and anticipated in the future, as well as the demographics of the County's employees and retirees; and to make recommendations as to how the County could attempt to control its health care costs.

4. Over the next several months, PEBS reviewed the County's data to understand the nature of the County's challenge and to project how the County's costs would project into the future. During our review, we found the County's health care costs (excluding dental costs) had increased by approximately seventy percent (70%) from 1999 to 2002. A copy of the County's health care costs from this period is attached as Exhibit B-1.

5. In large part, the County's problem with health care costs was caused by the antiquated health insurance coverage the County was providing for employees and retirees. In 1977, the County provided retirees with fee-for-service health insurance that included prescription drug coverage with a two dollar ($2.00) co-payment. In terms of 2004 dollars, the 1977 prescription drug co-payment would be equivalent to a co-payment of approximately $6.08 after being adjusted for inflation based upon the CPI. If one used the rate of inflation in health care services to determine the amount of a $2.00 co-payment from 1977 would cost in 2004 dollars, the cost of the $2.00 co-payment from 1977 when adjusted for inflation would be $13.41 in 2004 dollars.

6. Since 1977, there have been significant changes to the manner in which insurance companies provide health insurance and prescription drug coverage for employees and retirees.

7. Since 1977, employers have been able to control the escalating costs of prescription drugs by encouraging the use of generic drugs. Employers have encouraged the use of generic drugs by charging higher co-payments for employees and retirees using Name Brand drugs. In 1984, 19% of the prescription drugs sold were generic drugs according to a July 1998 report from the Congressional Budget Office. By 1996, this figure had increased to 46%. Encouraging the use of generic drugs has allowed employers to recognize significant cost savings, inasmuch as the average generic drug cost is approximately $21.00 and the average Name Brand drug cost is $84.00.

8. More recently, employers have adopted insurance provisions that encourage the use of mail-order prescription drug fills, which allow members to obtain a three-month supply of certain so-called maintenance drugs through the mail for the payment of a single co-payment. Because mail-order prescription programs have much lower costs, employers are able to achieve significantly lower prescription costs by using mail-order prescription drug fills.

9. There have also been substantial changes in the manner in which health insurance is provided. One of the most notable changes has been the development of the Preferred Provider Organization ("PPO"). In a PPO, the insurance company contracts with medical providers, who agree to charge for services based upon a negotiated fee schedule, which represents a discounted rate from the normal fee for service charges. Unlike an HMO, a PPO does not seek to limit utilization of health services by restricting access to health care through a so-called gatekeeper. The usual tradeoff in adopting a PPO is that not every provider will be a participant in the insurance company's PPO and members are required to pay greater fees when using a provider outside of the PPO network. Employers are able to provide better health insurance at a comparable cost through the use of a PPO, as a result of the discounted rate paid to providers. PPOs also attempt to limit cost by expanding the coverage for preventive health measures and tests that are not typically covered by Traditional Fee-for-Service insurance products.

10. We projected that if the County made no changes to its health care costs the County would be paying in excess of $4.5 Million annually for retiree health care costs by 2007 and in excess of $20 Million annually for employee and retiree health care costs by 2013. A copy of our projected health care expenditures is attached as Exhibit C-1. To control these escalating costs, we made several recommendations to the County regarding the manner in which the County could limit the growth of future health care costs to more manageable levels.

11. We recommended the County change their existing health insurance coverage from Blue Cross/Blue Shield Traditional fee-for-Service insurance to Blue Cross / Blue Shield's Community Blues PPO Option 2 ("Community Blues 2") for several reasons. First, Community Blues 2 provides insurance coverage for a broader array of procedures than that covered under the fee-for-service option. A comparison of the coverage provided by each is attached as Exhibit D-1. Second, our review of the County's current utilization found that the vast majority of the providers in the County were already participating in Community Blues 2. Our review indicated that 315 providers in the County accepted Blue Cross Blue Shield Traditional fee for service insurance, whereas 317 providers in the County participated in Community Blues 2. By switching to Community Blues 2, we believed the County could expand the coverage provided to retirees at a slightly higher cost, while at the same time allowing employees and retirees to continue to use their existing providers.

12. We recommended the County modify its existing prescription drug coverage for employees and retirees to promote the use of generic drugs and to provide a mail order option for

maintenance drugs. We recommended the County consider adopting a two-tier co-payment structure, whereby employees and retirees would pay a $10 co-payment for generic prescriptions and a $20 co-payment for brand-name prescriptions. This modified co-payment provides employees and retirees with a financial incentive to use the lower-priced generic drugs.

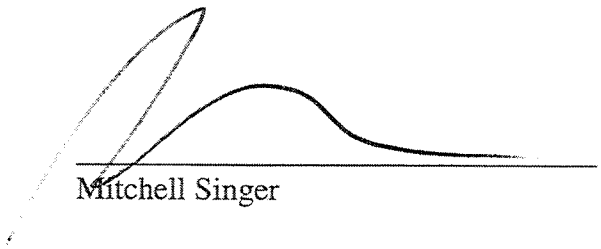
13. We also emphasized the availability of mail-in prescription fills for maintenance drugs. Our experience with comparably-sized counties is that over fifty percent of the prescriptions filled for retirees are for so-called maintenance drugs, meaning drugs that are used for long-term health maintenance as opposed to treatment of acute conditions. Because 90 day supplies of maintenance drugs can be purchased through the mail with the member only being charged a single co-payment (under the current system an individual would be charged 3 co-payments for a 90 day supply of such maintenance drugs filled at a pharmacy), we recommended the County strongly encourage the use of mail-in prescription fills to decrease the financial impact of the increased co-payment.

14. The County adopted our recommendations regarding the co-payment provision. However, the County expressed concern about certain retirees who had pensions of less than $20,000 a year. Approximately, 22.1% of the County's retirees in October 2003 had retirement income of less than $20,000.00. To defray the impact the increased co-payment might have on these persons, the County adopted a hardship provision, which set the co-payment for such individuals to $5.00. If these persons use the mail-order prescription for maintenance drugs, the net effect of the new changes would be to reduce the total co-payment for maintenance drugs from $6.00 for three months (the co-payment cost of three prescription fills at a pharmacy) to $5.00 for a mail-order fill.

15. As a result of the changes implemented by the County, the County will be better able to control the rate at which such costs increase in the future. In 2004 alone, we project the County will avoid $458,724.00 in additional retiree health care costs as a result of the aforementioned changes to its retiree health insurance.

16. In my professional opinion, the increased scope of coverage provided by Community Blues 2 offsets the changes in the County's prescription drug co-payment to provide County retirees with an equivalent mix of health care benefits.

Further Affiant sayeth not.



Mitchell Singer

On the 8th day of November, A.D. 2004, before me personally appeared Mitchell Singer and made oath that he has read the foregoing Affidavit by him subscribed and knows the contents thereof, and that the same is true of his own knowledge, except as to the matters which are therein stated to be upon his information and belief, and as to those matters, he believes them to be true.

Kathleen A. Walker

Notary Public
St. Clair County, Michigan
My commission expires: 3/15/07

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF ST. CLAIR

ST. CLAIR COUNTY RETIREES ASSOCIATION (SCCRA), a Voluntary Non-Profit Association,
Plaintiffs,

vs.

File No. K 04-672 CK

COUNTY OF ST. CLAIR, a Michigan Municipal Corporation,
Defendants.

JOHN B. McNAMEE (P27939)
ROBERT W. CARSON (P23259)
McIntosh, McColl, Carson, McNamee, Strickler & Downey
Attorneys for Plaintiffs
3024 Commerce Drive
Fort Gratiot, Michigan 48059
(810) 385-1500

GARY A. FLETCHER (P26823)
WILLIAM L. FEALKO (P52156)
Fletcher Clark Tomlinson Fealko & Monaghan, P.C.
Attorneys for Defendants
522 Michigan Street
Port Huron, Michigan 48060-3811
(810) 987-8444

AFFIDAVIT OF MITCHELL SINGER

STATE OF MICHIGAN
-ss-
COUNTY OF Saginaw

Mitchell Singer, being first duly sworn deposes and says:

1. I have personal knowledge of the facts set forth herein and if called upon to testify would testify consistent with the following statements.

2. I am a principal with Public Employee Benefits Solutions, L.L.C. ("PEBS"), an Insurance Agency that provides consulting services to public employers regarding Employee Benefits. I have been working in the insurance industry for 18 years. A current copy of my curriculum vitae, and that of the other Principal of the company is attached as Exhibits A-1 and A-2, respectively.

3. In March 2003, we were asked by St. Clair County (the "County") to review the County's costs for health insurance, life insurance and other benefits; to project the County's future costs based upon cost trends being experienced and anticipated in the future, as well as the demographics of the County's employees and retirees; and to make recommendations as to how the County could attempt to control its health care costs.

4. Over the next several months, PEBS reviewed the County's data to understand the nature of the County's challenge and to project how the County's costs would project into the future. During our review, we found the County's health care costs (excluding dental costs) had increased by approximately seventy percent (70%) from 1999 to 2002. A copy of the County's health care costs from this period is attached as Exhibit B-1.

5. In large part, the County's problem with health care costs was caused by the antiquated health insurance coverage the County was providing for employees and retirees. In 1977, the County provided retirees with fee-for-service health insurance that included prescription drug coverage with a two dollar ($2.00) co-payment. In terms of 2004 dollars, the 1977 prescription drug co-payment would be equivalent to a co-payment of approximately $6.08 after being adjusted for inflation based upon the CPI. If one used the rate of inflation in health care services to determine the amount of a $2.00 co-payment from 1977 would cost in 2004 dollars, the cost of the $2.00 co-payment from 1977 when adjusted for inflation would be $13.41 in 2004 dollars.

6. Since 1977, there have been significant changes to the manner in which insurance companies provide health insurance and prescription drug coverage for employees and retirees.

7. Since 1977, employers have been able to control the escalating costs of prescription drugs by encouraging the use of generic drugs. Employers have encouraged the use of generic drugs by charging higher co-payments for employees and retirees using Name Brand drugs. In 1984, 19% of the prescription drugs sold were generic drugs according to a July 1998 report from the Congressional Budget Office. By 1996, this figure had increased to 46%. Encouraging the use of generic drugs has allowed employers to recognize significant cost savings, inasmuch as the average generic drug cost is approximately $21.00 and the average Name Brand drug cost is $84.00.

8. More recently, employers have adopted insurance provisions that encourage the use of mail-order prescription drug fills, which allow members to obtain a three-month supply of certain so-called maintenance drugs through the mail for the payment of a single co-payment. Because mail-order prescription programs have much lower costs, employers are able to achieve significantly lower prescription costs by using mail-order prescription drug fills.

9. There have also been substantial changes in the manner in which health insurance is provided. One of the most notable changes has been the development of the Preferred Provider Organization ("PPO"). In a PPO, the insurance company contracts with medical providers, who agree to charge for services based upon a negotiated fee schedule, which represents a discounted rate from the normal fee for service charges. Unlike an HMO, a PPO does not seek to limit utilization of health services by restricting access to health care through a so-called gatekeeper. The usual tradeoff in adopting a PPO is that not every provider will be a participant in the insurance company's PPO and members are required to pay greater fees when using a provider outside of the PPO network. Employers are able to provide better health insurance at a comparable cost through the use of a PPO, as a result of the discounted rate paid to providers. PPOs also attempt to limit cost by expanding the coverage for preventive health measures and tests that are not typically covered by Traditional Fee-for-Service insurance products.

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structure, whereby employees and retirees would pay a $10 co-payment for generic prescriptions and a $20 co-payment for brand-name prescriptions. This modified co-payment provides employees and retirees with a financial incentive to use the lower-priced generic drugs.

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16. In my professional opinion, the increased scope of coverage provided by Community Blues 2 offsets the changes in the County's prescription drug co-payment to provide County retirees with an equivalent mix of health care benefits.

Further Affiant sayeth not.

Mitchell Singer

On the 30th day of April, A.D. 2004, before me personally appeared Mitchell Singer

and made oath that he has read the foregoing Affidavit by him subscribed and knows the contents thereof, and that the same is true of his own knowledge, except as to the matters which are therein stated to be upon his information and belief, and as to those matters, he believes them to be true.

Jennifer Ann Panko

Notary Public
Saginaw County, Michigan
My commission expires: June 19, 2005

JENNIFER ANN PANKO
NOTARY PUBLIC SAGINAW CO., MI
MY COMMISSION EXPIRES Jun 19, 2005

Exhibit A-1
RESUME

Mitchell T. Singer
6628 Dixie Highway
P.O. Box 555
Bridgeport, Mi. 48722
Work (989) 746-0209 Ext. 10 Fax (989) 746-0885
Cell Phone (989) 592-8646

EXPERIENCE

Public Employee Benefits Solutions L.L.C. – Principal Formed January 2003

Formed a partnership with Fred D. Todd to address fringe benefits issues facing public entities. Our primary focus is finding cost effective ways to assist public entities with managing their fringe benefit cost. We currently have a substantial client base in the public sector due to our success in reducing or controlling health insurance, dental insurance, life insurance and disability insurance cost, by using creative financing methods and cutting edge ideas.

National Employee Benefits Solutions, Inc. – President Formed July 2002

Formed a new national corporation to address fringe benefits issues facing private sector clients nationwide. Again our primary focus is to find cost effective ways to assist companies with creatively managing their fringe benefit cost. We currently have a substantial client base in 22 states that can be primarily attributed to our tremendous success in Michigan in helping our clients reduce or contain fringe benefit cost.

Employee Benefits Resources Inc. - President Formed January 1991

Formed a corporation with Ron Schoen that focuses strictly on employee benefits and insurance primarily in the private sector in Michigan. This original agency has shown exceptional growth because we have been able to assist our clients contain or control employee benefit cost. This company has gained the experience required to professionally develop imaginative programs that are transferable to our other agencies.

EDUCATION

Michigan State University - General Studies

SAMPLING OF KEY PRESENTATIONS MADE IN 2003

"Health Care Cost Trends and Ideas" Waterford Chamber of Commerce March 2003

"Reducing Fringe Benefit Costs" Michigan Local Government Managers Association, Annual Conference at Crystal Mountain, July 2003

"Overview of Fringe Benefits Cost Containment Ideas For The Public Sector" Michigan Public Employer Labor Relations Association Annual Conference at Shanty Creek, October 2003

"Overview of Insurance Trends, Cost and Solutions" Gratiot Area Chamber of Commerce, Alma, Michigan November 2003.

Exhibit A-2
RESUME

FRED D. TODD J.D.
6628 Dixie Highway
P.O. Box 555
Bridgeport, Mi. 48722
Work (989) 746-0209 Ext. 33 Fax (989) 746-0885
Cell Phone (989) 592-8646

EXPERIENCE

Public Employee Benefits Solutions L.L.C. – Principal January 2003 to Current. Formed a partnership with Mitchell Singer to address fringe benefits issues facing public entities. Our primary focus is finding cost effective ways to assist public entities with managing their fringe benefit cost. We currently have a substantial client base in the public sector due to our success in reducing or controlling health insurance, dental insurance, life insurance and, disability insurance cost, by using creative ideas.

21st Century Public Consultants L.L.C. – President. January 2001 to Current. Operates a consulting practice which focuses on the governmental and not-for- profit sectors, specializing in the areas of human resources and labor relations, capital financing, financial and organizational analysis, strategic planning, employee benefit insurance, retirement system planning and general administration. These important services are designed foremost to assist each local government in reducing or containing cost where possible and improve organizational efficiency.

Rehmann Robson - Director, Governmental Consulting Services. October 1999 to December 31, 2000. Responsible for developing and expanding the governmental consulting practice for one of the Midwest largest accounting firms, with about 400 professionals in eleven Michigan cities. Performed numerous studies related to financing fringe health and retirement benefits, post retirement health studies, staffing plan for fire department and police, fire and EMS reorganization plan for a joint authority.

Saginaw County, MI - Controller/Chief Administrative Officer. Population 212,000. January 1989 to September 1999 - 10 ¾ years. Retired 9-30-1999 to enter the private sector. Responsible for the overall management and administration of the County, with a total annual budget of $120 million with 778 employees, down from $170 million and 1,620 employees in 1988. Lead efforts to reorganize county government and performed numerous staffing plans working cooperatively with elected and appointed officials. Was a key player in eliminating a General Fund operating deficit of $3.4 million. By Fiscal Year ended 9/30/99 the General's Fund's surplus was $21 million on a budget of $41 million. Also made extensive changes to the County's insurance and pension plans, which were designed to decrease cost and provide more flexibility and choices for the employees.

21st Century Public Consultants L.L.C. – President January 1987 to December 1988 – 2 years. Operated a consulting practice while attending law school full-time. The practice focused on the governmental, not-for- profit and trust clients, specializing in the areas of financial and organizational management, strategic planning and retirement system planning and administration.

Wayne County, MI - Chief Financial Officer and Director of Management and Budget. Population 2,100,000. **April 1983 to January 1987 - 4 years.** Supervised a staff of 400 employees, in a county with employment of 5,200 employees. Responsible for the overall financial management, administration, and preparation, monitoring and balancing of a $689 million budget. Helped eliminate a $32 million General Fund operating deficit. Restructured and reorganized numerous County departments and revamped fringe benefit programs saving the County millions of dollars over a four-year period.

Ingham County, MI - Controller/Chief Administrative Officer. Population 285,000. **January 1978 to July 1983 - 5 ½ years.** Responsible for the general management and administration of the County with a 1983 budget of $93 million, and 2,700 employees. Reorganized the County government structure and performed several staffing studies for various departments. Designed and implemented a self-funded insurance and workers compensation program, which saved the County substantial outlays.

City of Novi, MI - Finance Director and Treasurer. January 1976 to December 1977 - 2 years.

City of Madison Heights, MI – Asst. Finance Dir./Treasurer. February 1974 to December 1976 - 2 years.

Auditor G & W, Inc., Auditor, Fruehauf Corporation, and Auditor, Total Petroleum. 1969 to January 1974 - 5 years. Worked full-time as an auditor while attending college full-time.

EDUCATION

Juris Doctor - Thomas M. Cooley Law School – Graduated with honors.
Master of Public Administration - University of Michigan – Graduated with honors.
Master Business Administration - Indiana Northern University – Graduated with honors.
Bachelor of Science in Accounting - Detroit College of Business – Graduated with honors.
Diploma in Accountancy and Financial Administration - Walsh College – Graduated with honors.

CURRENT AND PREVIOUS PROFESSIONAL ORGANIZATIONS

American Bar Assoc.
Government Finance Officers Assoc.
Mi. Assoc. of County Administrative Officers
Michigan City/County Managers Assoc.
NationalAssoc.County Admin.
InternationalCity/County Managers.
State Bar of Michigan
Saginaw County Bar Assoc.

SAMPLING OF COLLEGES WHERE I HAVE TAUGHT

Madonna College – Livonia, Mi.
Mercy College – Detroit, Mi.
Oakland County Community College – Highland Lakes, Mi.
Walsh College – Troy, MI.
Wayne State – Detroit, MI.

SAMPLING OF PUBLICATIONS

"Saginaw County, Finding Answers For Your Employees and a Jurisdiction," Government Finance Review, *December 1997.*

"Implementing a Defined Contribution Plan for Saginaw County, Michigan," *December, 1994*

"Michigan Comparable County Study," January 1992.

"Michigan Comparable County Study," September 1989.

"Report From Wayne County," October 1985, City and State Magazine.

"Michigan County Government Administration," July 1981.

"Compulsory Arbitration and the Right to Strike for Public Sector Employees in Michigan," 1980.

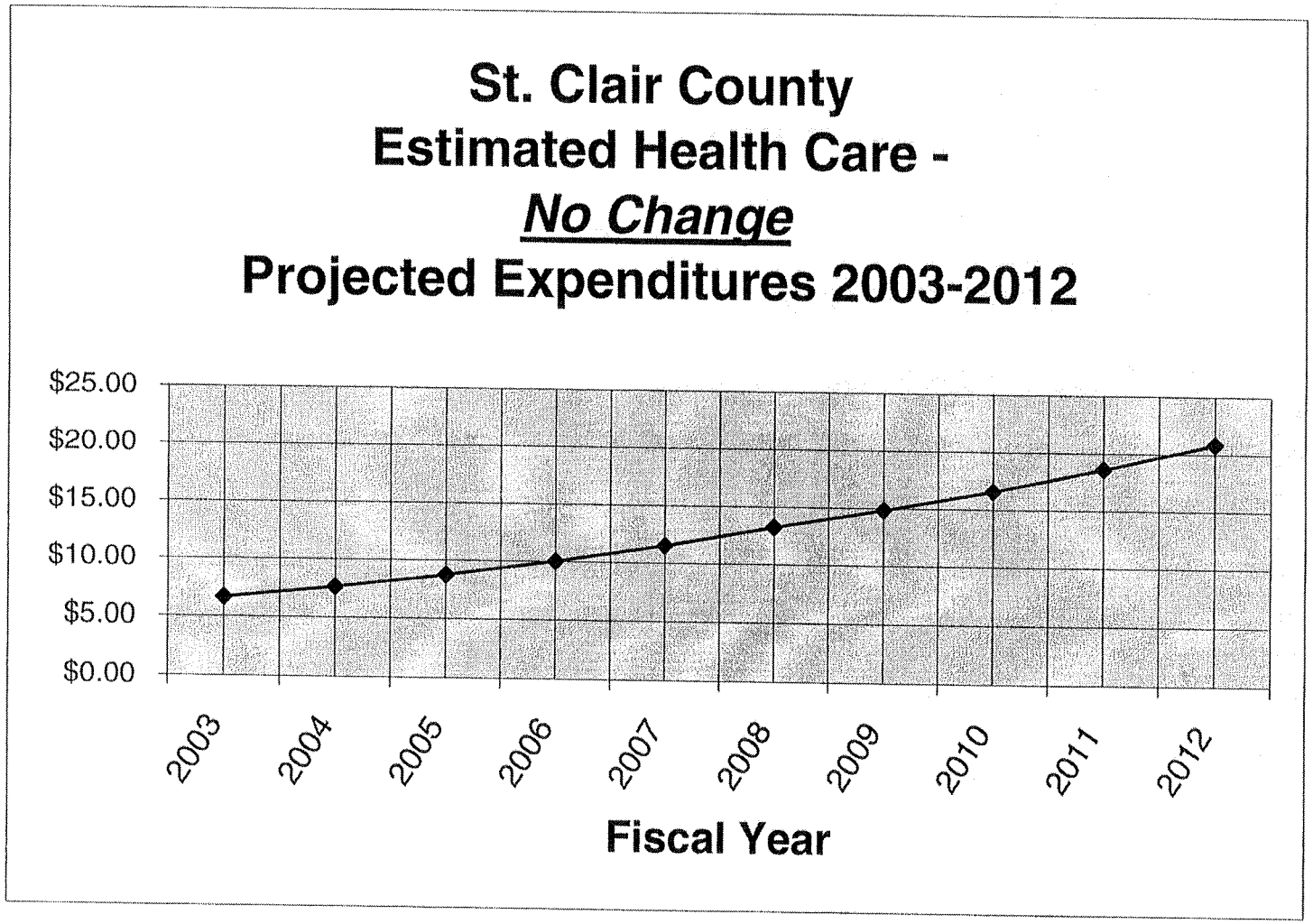
Exhibit B-1

Historical Analysis *

	Contract Year	Projected Expenses	Percent Change
	2000	$4,375,522	
	2001	$5,476,062	27%
	2002	$5,951,981	16%
	2003	$6,578,760	12%
Average		**$5,595,581**	**18%**

* This information was provided to the group as Exibit I of their 2004 renewal

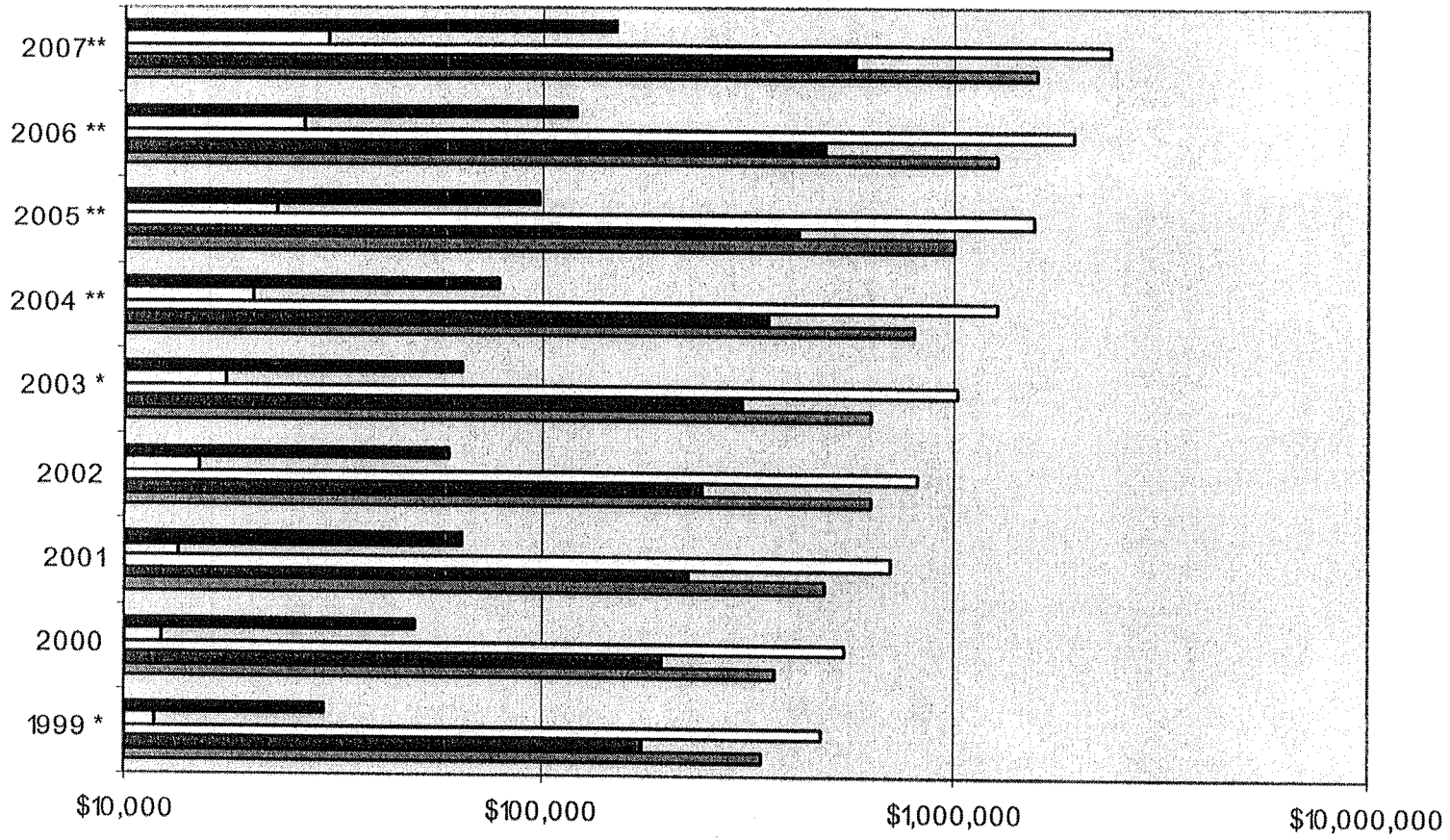
Exhibit C-1



Fiscal Year

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenditures In ***Millions***	$6.58	$7.57	$8.71	$10.01	$11.52	$13.24	$14.83	$16.61	$18.60	$20.84
Percent Increase		15.00%	15.00%	15.00%	15.00%	15.00%	12.00%	12.00%	12.00%	12.00%

Retiree Cost Comparison



	1999*	2000	2001	2002	2003*	2004**	2005**	2006**	2007**
DENTAL	$30,042	$49,462	$63,956	$59,307	$64,000	$79,134	$97,847	$120,985	$149,594
#OFSCRIPTS	$11,738	$12,209	$13,389	$15,027	$17,536	$20,133	$23,115	$26,539	$30,470
DRUGS	$472,184	$540,001	$704,127	$820,606	$1,023,298	$1,265,389	$1,564,754	$1,934,942	$2,392,708
PHYSICIAN	$173,350	$195,935	$227,124	$242,896	$302,098	$354,379	$415,708	$487,650	$572,043
HOSPITAL	$339,037	$364,477	$486,095	$628,370	$633,471	$797,340	$1,003,600	$1,263,215	$1,589,990

Exhibit D-1

Med-E-Fill
Benefits-at-a-Glance

In-network benefits	Current Plan	Non-Medicare	Medicare Eligible	
	Traditional	Community Blue 2	Medicare	Med-E-Fill Coverage
Preventive Services				
Health Maintenance Exam	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Not Covered	Covered – 100% of BCBSM approved amount, one per 12 months. Subject to the preventive dollar maximum
Gynecological Exam	Not covered	Covered – 100%, once per calendar year. (No age restrictions) (In-Network only)	Covered – 80% of approved amount, once every 24 months. Age 50 and older. (More frequently if at high risk)	• Covers – Medicare co-insurance • When not covered by Medicare – Covered 100% of BCBSM approved amount, one per 12 months, subject to preventive dollar maximum (No age restrictions)
Pap Smear Screening – laboratory services only	Covered-$5 or 10% copay, whichever is greater, one every 12 months (from date of any previous pap smear)	Covered – 100%, once per calendar year. (In-Network only)	Covered – 100% of approved amount, once every 24 months. (More frequently if at high risk)	• Covered in full by Medicare • When not covered by Medicare –
Fecal Occult Blood Test	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Covered – 100% of approved amount, once every 12 months. Age 50 and older	• Covered in full by Medicare • When not covered by Medicare – Covered 100% of BCBSM approved amount, one per 12 months, subject to preventive dollar maximum (No age restrictions.)
Flexible Sigmoidoscopy	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Covered – 75% of approved amount after Part B deductible once every 48 months age 50 and older	• Covers Medicare coinsurance and deductible.
Prostate Specific Antigen (PSA) Test	Not covered	Covered – 100%, once per calendar year. (No age restrictions) (In-Network only)	Covered – 100% of approved amount, once every 12 months at age 50 and older	• Covered in full by Medicare • When not covered by Medicare – Covered 100% of BCBSM approved amount, one per 12 months, subject to preventive dollar maximum
EKG	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Not Covered	Covered – 100%, one per 12 months
Chest X-Ray	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Not Covered	Covered – 100%, one per 12 months
Urinalysis	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Not Covered	Covered – 100%, one per 12 months
Complete Blood Count	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Not Covered	Covered – 100%, one per 12 months

Preventive Services (Continued)

Chemical Profile	Not covered	Covered – 100%, once per calendar year. (In-Network only)	Not Covered	Covered – 100%, one per 12 months
Vaccinations				
• Flu Shots and Pneumonia Vaccines	Not covered	Not covered	Covered – 100% of approved amount	Covered in full by Medicare
• Hepatitis B Vaccines – for those at risk of contracting the disease	Not covered	Not covered	Covered – 80% of approved amount after Part B deductible	Only covered by Medicare
Well-Baby and Child Care	Not covered	Covered – 100%	Not Covered	Covered – 100%

		▪ 6 visits for children from 0 to 12 months ▪ 6 visits for children 12 months up to 24 months ▪ 2 visits per birth year for children from 24 months through 48 months ▪ 1 visit per birth year for children from 4years through 15 years		▪ 6 visits for children from 0 to 12 months ▪ 6 visits for children 12 months up to 24 months ▪ 2 visits per birth year for children from 24 months through 48 months ▪ 1 visit per birth year for children from 4years through 15 years

Mammography

Mammography Screening	Covered-$5 or 10% copay, whichever is greater, one baseline for ages 35-40, one annually at age 40 and older	Covered 90%, once per calendar year after deductible	Covered – 80% of approved amount after Part B coinsurance. One baseline for ages 35-39, one every 12 months at age 40 and older	Covers Medicare coinsurance and deductible Covered - 90% of BCBSM approved amount under age 35 and if not covered by Medicare

Physician Office Services

Office Visits	Not covered	Covered - $15 copay	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance after a $15 co-pay
Outpatient and Home Visits	Not covered	Covered –90% after deductible	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance after a $15 co-pay
Office Consultations	Not covered	Covered - $15 co-pay	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance after a $15 co-pay
Urgent Care Visits	Not covered	Covered - $15 co-pay	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance after a $15 co-pay

	Traditional	Community Blue 2	Medicare	Med-E-Fill Coverage
Emergency Medical Care				
Hospital Emergency Room – (Facility)	Covered 100%	Covered - $50 copay, waived if admitted or an accidental injury	Covered – 80% of approved amount after Part B deductible	Covered - $50 copay, waived if admitted or an accidental injury
Emergency Room Physician's Services	N/A	Covered - $15 co-pay	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance after a $15 co-pay
Ambulance Services – Must be medically necessary	Covered 100%	Covered – 90% after deductible	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance
Clinical Laboratory Services				
Laboratory and Pathology Tests – used in the diagnosis and treatment of an illness or injury	Covered-$5 or 10% copay, whichever is greater, for outpatient and office services	Covered – 90% after deductible	Covered – 100% of approved amount for most diagnostic laboratory and pathology services Covered – 80% for certain laboratory services	Covered in full by Medicare Covered Medicare coinsurance when applicable
Radiology Services				
X-Rays – used in the diagnosis and treatment of an illness or injury	Covered-$5 or 10% whichever is greater	Covered – 90% after deductible	Covered – 80% after Part B Deductible	Covers Medicare deductible and coinsurance
Maternity Services				
Delivery	Covered -100% includes delivery provided by a certified nurse midwife	Covered – 90% after deductible	Covered – 80% after Part B Deductible	Covers Medicare deductible and coinsurance
Pre and Post Natal Care	Not covered	Covered 100%	Not Covered	Covered 100%
Hospital Care				
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies • Days 1-60	Covered-100% up to 365 days, 60 day renewal	Covered – 90% after deductible, unlimited days	Covered – 100% of approved amount after Part A deductible. (Also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible
• Days 61-90			Covered – 100% of approved amount after Part A daily coinsurance	Covers Medicare daily coinsurance
• Lifetime Reserve Days (60 days)			Covered – 100% of approved amount after Part A daily	Covers Medicare daily coinsurance
• Additional Days			Not Covered	Covered at BCBSM approved amount, unlimited days
Alternatives to Hospital Care				
Skilled Nursing Facility Care – specific criteria applies				
• Days 1-20	Not covered	Covered –90%, up to 120 days per year	Covered – 100% of approved amount	Covered in full by Medicare
• Days 21-100	Not covered		Covered – 100% of approved amount after daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	Not covered		Not Covered	Covered at BCBSM approved amount up to an additional 20 days
Hospice Care	Not covered	Covered 100%, limited to the lifetime dollar maximum, which is adjusted periodically.	Covered at Medicare approved amount less small copayment for outpatient drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare, at 100%
Home Health Care – medically necessary	Not covered	Covered 90%, after deductible, unlimited visits	Covered – 100% of approved amount	Covered in full by Medicare

	Traditional	Community Blue 2	Medicare	Med-E-Fill Coverage
Surgical Services Provided by a Physician				
Surgery – includes related surgical services	Covered-100%	Covered – 90% after deductible	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance
Human Organ Transplants				
Specified Organ Transplants – designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered-100% , up to $1 million maximum per transplant type	Covered – 90% after deductible, in designated facilities, up to $1 million maximum per transplant type	Covered – 80% of approved amount after deductible Please call Medicare for more	Covers Medicare deductible and coinsurance up to $1 million maximum per transplant type (In designated facilities)
Specified Organ Transplants – Pancreas only. Designated Facilities only, when coordinated through the BCBSM Human Organ Transplant Program. (1-800-242-3504)	Covered-100% , up to $1 million maximum per transplant type	Covered – 90% after deductible, in designated facilities, up to $1 million maximum per transplant type	Not Covered **Note:** Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Covers Medicare deductible and coinsurance when covered by Medicare up to level of group's coverage. Covered – 90%, in designated facilities, up to $1 million maximum per transplant type when not covered by Medicare.
Bone Marrow Transplant when coordinated through the BCBSM Human Organ Transplant Program. Specific criteria apply.	Covered-100%	Covered – 90% after deductible	Covered – 80% of approved amount after deductible	Covers Medicare deductible and coinsurance

(1-800-242-3504)			Please call Medicare for more information	
Kidney, Cornea and Skin Transplants	Covered-100%	Covered –90% after deductible, (In-Network)	Covered – 80% of approved amount after deductible Please call Medicare for more information	Covers Medicare deductible and coinsurance

Mental Health Care	Traditional	Community Blue 2	Medicare	Med-E-Fill Coverage
Inpatient Mental Health Care in psychiatric facility • Days 1-190 **Lifetime**	Covered-100% up to 45 days, 60 day renewal	Covered – 50% after deductible, up to 60 days per calendar year, 120 days lifetime	Covered – 50% of approved amount after Medicare deductible **Note**: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covered only by Medicare
• Additional Days after 190 lifetime days are used			Not Covered	Not Covered
Outpatient Mental Health Care	Not Covered	Covered – 50% after deductible, up to 50 visits per calendar year and 120 visits lifetime	Covered – 50% of approved amount after Part B deductible or set coinsurance for therapeutic services. Diagnostic services are covered at 50% of approved amount less Part B deductible	Covered only by Medicare
Residential Substance Abuse	N/A	Covered – 50% after deductible, up to 60 days per calendar year, 120 days lifetime (Combined with inpatient mental health days)	(See Hospital Care benefit.) Claims are subject to Part A deductible and daily coinsurance	Covers Medicare Part A deductible and daily co-insurance
Outpatient Substance Abuse	Covered-100%, up to 60 consecutive days of treatment per condition	Covered – 50% after deductible, up to the state mandated dollar amount, which is adjusted annually (In and Out-of-Network)	Covered – 50% after Part B deductible, unlimited visits	Covered only by Medicare
Other Services				
Outpatient Diabetes Management Program (Includes syringes)	Covered-100%	Covered – 100%	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance
Allergy Testing and Therapy – with approved diagnosis	Not Covered	Covered – 100%	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance
Chiropractic Spinal Manipulation – must be medically necessary	Not Covered	Covered – 100% up to 24 visits per calendar year (In-Network)	Covered – 80%, when medically necessary, of approved amount after Part B deductible	Covers Medicare deductible and coinsurance up to 24 visits per calendar year
Chiropractic X-ray	Covered-$5 or 10% copay, whichever is greater	Covered – 100% (In-Network)	Not Covered	Covered – 100% of BCBSM approved amoun
Outpatient Physical, Speech and Occupational Therapy	Covered-100% up to 60 consecutive days of treatment per condition	Covered – 90% after deductible, up to 60 visits per calendar year. (In-Network)	Covered – 80% of approved amount after Part B deductible **Note**: Services of independent physical or occupational therapist subject to annual dollar limit.	Covers Medicare deductible and coinsurance up to 60 visits per calendar year
Durable Medical Equipment	Not covered	Covered - 90% after deductible	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic Appliances	Covered-100%, only for certain external prosthetics	Covered - 90% after deductible	Covered – 80% of approved amount after Part B deductible	Covers Medicare deductible and coinsurance
Home Infusion Therapy	Covered 100% (H.I.T. contracted providers only)	Covered –90% after deductible (H.I.T. contracted providers only)	Covered – 80% after Part B deductible for limited services.	▪ Covers – Medicare co-insurance ▪ When not covered by Medicare – Covered 90% of BCBSM approved amount. (H.I.T contracted providers only)
Private Duty Nursing	Not Covered	Covered – 50% after deductible	Not Covered	Covered – 50% of BCBSM approved amount
Oral Cancer Drugs	Covered - according to RX	Covered - according to RX	Approved drugs are covered	Covered in full by Medicare
Prescription Drug Coverage	$2.00 MOPD-1	$10/20 MOPD		Based on the group's level of benefits

	Traditional	Community Blue 2	Medicare	Med-E-Fill Coverage
Foreign Travel				
Hospital Services	covered same as services in United States	Covered – 90% after deductible, up to the group's level of benefits, subject to applicable copays	Not Covered, except for inpatient hospital services in Canada or Mexico in rare situations	Covered – 90% up to the group's level of general benefits Covered – 50% for mental health and substance abuse benefits
Physician Services	covered same as services in United States	Covered – 90% after deductible, up to the group's level of benefits, subject to applicable copays	Not Covered, except for services rendered in Canada or Mexico in connection with a covered inpatient stay	Covered –90% up to the group's level of general benefits Covered – 50% for mental health, substance abuse and private duty nursing benefits
Deductible, Copays and Dollar				
Deductibles:	None	In-Network $100/$200 Out-of-Network – $250/$500	Part A - $812 Part B - $100 (Effective 1/1/2002)	Based on the group's level of benefits
Copays: **Fixed:**	$5 or 10%, whichever is greater, for diagnostic services and x-rays	In-Network – $15 for office visits $50 for emergency room visits Out-of Network – $50 emergency room visits	Hospital (61-90 days) $203 (91 –150 days) $406 Skilled Nursing (21-100 days) $101.50 20% for most general services 25% for sigmoidoscopys	$15 for office visits $50 for emergency room visits
Percent:	N/A	In-Network – ▪ 90% ▪ 50% for mental health, substance abuse and private duty nursing Out-of-Network – ▪ 70% ▪ 50% for mental health, substance abuse and private duty nursing	50% for outpatient mental health and substance abuse	Based on the group's level of benefits 50% - Private Duty Nursing
Dollar Maximums: **Preventive Services:**	None	$250	None	$250
Copay Maximums:	None	$500/$1000 (in Network) $1500/$3000 (out of Network)	None	$500/$1000 (in Network) $1500/$3000 (out of Network)
Lifetime Maximums:	$1 million lifetime	$5 Million	None	$5 million

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield certificate and riders.

St. Clair County EMPLOYEES' RETIREMENT PLAN

Adopted January 1, 1964
Amended January 1, 1972
Amended January 1, 1979
Amended January 1, 1990
Amended January 1, 1992

AN ORDINANCE AMENDING AND RESTATING THE ST. CLAIR COUNTY EMPLOYEES' RETIREMENT SYSTEM ORDINANCE TO INCORPORATE ACCUMULATED CHANGES, REMOVE OBSOLETE MATERIAL, AND TO CONFORM TO APPLICABLE PROVISIONS OF STATE AND FEDERAL LAW.

BE IT ORDAINED BY THE BOARD OF COMMISSIONERS OF THE COUNTY OF ST. CLAIR:

that the St. Clair County Employees' Retirement System ordinance is hereby amended and restated in its entirety to read as follows:

ARTICLE I

Retirement System Effective Date; Continuation; Purpose.

Section 1.1. The St. Clair County Employees' Retirement System, under the authority of Section 12a of Act No. 156, of the Public Acts of 1851, as added by Act No. 249 of the Public Acts of 1943, as amended, is continued for the purpose of providing retirement income to qualifying employees and former employees, and survivor income to their qualifying beneficiaries.

Short Title; Application; Effective Date of Restatement.

Section 1.2. (a) This ordinance may be cited as the St. Clair County retirement ordinance.

(b) This restatement will apply to individuals employed by the county on and after the effective date of the restatement. The retirement rights of an individual whose county employment terminated before the effective date of this restatement will be governed by the provisions of the retirement system ordinance in effect on the date the individual last terminated county employment.

(c) This ordinance shall become effective immediately upon final passage by the Board of Commissioners of the County of St. Clair on January 1, 1992 and after having been approved by the county pension plan committee if required under MCLA 46.12a (13).

Financial Benefits; Annual Funding.

Section 1.3. (a) The accrued financial benefits of each pension plan and retirement system of the state and its political subdivisions shall be a contractual obligation thereof which shall not be diminished or impaired thereby.

(b) Financial benefits arising on account of service rendered in each fiscal year shall be funded during that year and such funding shall not be used for financing unfunded accrued liabilities.

ARTICLE II

Definitions.

Section 2.1. As used in this ordinance:

(a) "Accumulated member contributions" means the balance in a member's individual account in the reserve for member contributions.

(b) "Beneficiary" means an individual who is being paid or who has entitlement to the future payment of a pension on account of a reason other than the individual's membership in the retirement system.

Survivor Pension; Elective Beneficiary; Conditions for Coverage.

Section 9.4. (a) A member may name a contingent survivor beneficiary for the exclusive purpose of being paid a pension under the provisions of this section. The naming of a contingent survivor beneficiary shall be made on a form provided by and filed with the retirement system.

(b) A pension shall be paid to the named contingent survivor beneficiary, if each of the following conditions are met:

(1) The member dies while an employee of the county.

(2) The member, at time of death, has twenty-five or more years of credited service; or, is age fifty years or older and has fifteen or more years of credited service.

(3) The named contingent survivor beneficiary is found by the Board of Trustees to have been dependent upon the deceased member for at least fifty percent of the individual's financial support.

Survivor Pension; Elective Beneficiary; Amount of Pension.

Section 9.5. The amount of pension paid to the elected beneficiary shall be computed as if the deceased member had retired under the normal retirement provisions (Article VI) the day preceding death, elected form of payment A, and named the elected beneficiary as survivor beneficiary. The pension shall terminate upon the death of the elected beneficiary.

ARTICLE X

Medical Insurance.

Section 10.1. Each retired member and beneficiary shall be provided coverage under a group medical insurance or pre-payment plan participated in by the county if the member meets the applicable requirements stated in section 10.2. The retired member's or beneficiary's qualified dependents shall be provided with medical insurance if the retired member or beneficiary is being provided medical insurance and the qualified dependents meet the requirements of section 10.4(d). The levels of coverage shall be as shown in section 10.3. The coverage shall be subject to the limitations stated in section 10.4.

Medical Insurance; Conditions for.

Section 10.2. The requirements for retired member medical insurance are:

(a) Benefit group general. The retired member or beneficiary is receiving a pension from this retirement system and has attained age fifty-five years. The age fifty-five requirement shall not apply if the retired member or beneficiary is totally physically or mentally disabled, or if the beneficiary has not yet attained age eighteen years.

(b) Benefit group sheriff deputy. The retired member or beneficiary is receiving a pension from this retirement system and the retired member has attained age fifty-five years. The age fifty-five requirement shall not apply if the retired member or beneficiary is totally physically or mentally disabled, or if the beneficiary has not yet attained age eighteen years.

Medical Insurance; Coverage Provided.

Section 10.3. The medical insurance shall provide the levels of coverage stated in this section or their equivalents.

(a) Blue Cross Blue Shield MVF.1.

(b) A prescription drug rider with two dollar co-pay.

(c) Dental insurance with a 50% co-pay and a $600 per person per contract year maximum. Coverage of orthodontic services shall not be provided.

Medical Insurance; Restrictions.

Section 10.4. The applicable retired member medical insurance shall be provided subject to the following restrictions.

(a) The retired member or beneficiary must apply for Medicare (or any other government sponsored program) when eligible. Upon qualification for such program, the retired member or beneficiary shall be provided coverage that is complementary to Medicare (or other government sponsored program). Insurance riders provided to other retired members shall also be provided on a complementary basis to retired members who have qualified for Medicare or other such program.

(b) There shall be a coordination of benefits with any other health insurance held by the retired member or beneficiary or the qualified dependents. In such coordination, the county's medical coverage shall be considered the secondary insurance.

(c) The retired member or beneficiary and the retired member's qualified dependents, if any, shall not be eligible for the medical insurance during any period when the retired member or beneficiary is employed and covered by such employer's health insurance program.

(d) The only persons covered by the retired member medical insurance as the retired member's or beneficiary's qualified dependents are the person to whom the retired member was married on the member's date of retirement and the children of the retired member or beneficiary until they attain age 18 years. The age 18 restriction shall be extended so long as the child is in school, but not beyond attainment of age 22 years. Subject to the other provisions of this section, the retired member's and beneficiary's qualified dependents shall be eligible for medical insurance as long as the retired member or beneficiary is alive and receiving pension payments, and after the retired member's death while the qualified dependent is receiving pension payments from this retirement system.

ARTICLE XI

Guaranteed Minimum Aggregate Payout.

Section 11.1. If all pension payments permanently terminate before there has been paid an aggregate amount equal to the retired member's, deceased member's, or deceased vested former members accumulated member contributions at time of retirement, the difference between the amount of accumulated member contributions and the aggregate amount of pension payments made shall be paid to such individual or individuals as the former member may have named on a form provided by and filed with the retirement system. If no such named individual survives, the difference shall be paid to the legal representative of the last to survive of an individual who was being paid a pension or the named individuals.

Death Benefit.

Section 11.2. Each retired member shall be covered by a death benefit in the amount of $3,000 payable to the retired member's estate or named beneficiary.

Pensions; Payment of.

Section 11.3. All payments from the retirement system shall be made by the county treasurer or as permitted by applicable law. Payments shall be made upon written authority signed by two persons designated by the Board of Trustees. Written authority to make payments shall only be executed based upon a specific or continuing resolution adopted by the Board.

of Commissioners, this Resolu
was tabled at Nov.23, 1976 me

Resolution 76-63

RESOLUTION AMENDING ARTICLE VI OF ST. CLAIR COUNTY EMPLOYEE'S RETIREMENT SYSTEM ORDINANCE

WHEREAS, the County of St. Clair desires to provide adequate benefits for those employees who have faithfully served the people of this County; and

WHEREAS, the County recognizes the needs of its retire employees and their families for health care; and

WHEREAS, the St. Clair County Employees' Retirement Plan does not presently provide for health care;

BE IT RESOLVED, that the St. Clair County Board of Commissioners do hereby amend the aforesaid Retirement Plan and adopt Section 5 of Article VI, as follows:

> "Any retirant or beneficiary within the provisions of this Retirement Plan, or any previous County Employees' Retirement Plan, shall receive medical and hospitalization benefits, consisting of MVF I plan and $2.00 co-payment prescription drug program."

BE IT FURTHER RESOLVED that this addition, to-wit: Article VI, Section 5, shall take effect January 1, 1977.

FURTHER, BE IT RESOLVED that the Retirement Board annually evaluate the cost of implementing said Section 5 of Article VI, above, and forward recommendations to the County Board Commissioners prior to budget review.

Drafted by:

PETER E. DEEGAN
County Corporation Counsel
289 County-City Building
Port Huronk Michigan 48060